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AMEND Senate Bill No. 2941 House Bill No. 2894*

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-32-226 is hereby amended by deleting subsection (b) in its entirety and substituting the following language:

(b) This subsection is intended to ensure the prompt and accurate payment of all provider claims for services delivered to an enrollee in the TennCare program which are submitted to a health maintenance organization involved in a TennCare line of business or a subcontractor of that organization. Accordingly, each such organization or subcontractor must establish and implement the following procedures for the processing of provider claims and the resolution of any disputes regarding the payment of such claims:

(1) The health maintenance organization shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are processed, and if appropriate paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. If a provider agreement requires the health maintenance organization to pay a provider a capitated payment each month, such payment shall be made by the time specified in the contract between the provider and the health maintenance organization. If the contract between the provider and health maintenance organization does not specify a payment schedule, payment shall

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be made by the tenth (10th) day of each calendar month. Disputed capitated provider payments are subject to independent review.

(A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation.

(2)

(A) If a provider's claim is partially or totally denied in a remittance advice or other appropriate written notice from a health maintenance organization, or a provider's previously allowed claim is subsequently partially or totally denied by a health maintenance organization by an appropriate written notice, then the provider may file a written request to

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the commissioner to submit the claim denial to an independent reviewer as provided in subdivision (b)(3). However, prior to sending this request, the provider must send a written request for reconsideration to the health maintenance organization which identifies the claim or claims in dispute, the reasons for the dispute and any documentation supporting the provider's position or request by the health maintenance organization. The health maintenance organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request The response may be a letter acknowledging the receipt of the reconsideration request with an estimated timeframe in which the health maintenance organization will complete its investigation and provide a complete response to the provider. If the health maintenance organization determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the health maintenance organization's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the health maintenance organization. If the health maintenance organization continues to deny the provider’s claims or the health maintenance organization does not respond to the reconsideration request within the time frames allowed herein, then the provider may file a

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written request with the commissioner to submit the claims denial to an independent reviewer as provided herein at subdivision (b)(3).

(B) The provider must include a copy of the written request for reconsideration with the request for an independent review. If the provider does not have a written contract with the health maintenance organization that denied the claim on the date the request is filed with the commissioner, then the provider must also send the commissioner payment satisfactory to the commissioner to cover the fees incurred by the independent reviewer. This payment shall be refunded to the provider if the provider is not ultimately required to pay the independent reviewer. Otherwise, the payment shall be used to reimburse any entity that paid the independent reviewer. The provider shall also furnish the commissioner any other information needed by the commissioner to process the provider's request.

(C) The provider must file a request for independent review within three hundred sixty-five (365) calendar days after the health maintenance organization denies the claim for the first time or recoups the claims payment.

(D) Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible for independent review.

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(3) Each health maintenance organization operating a TennCare line of business must contract with independent reviewers selected in accordance with subdivision (b)(4), and implement the following procedures to resolve disputed provider claims:

(A) The commissioner shall use his or her best efforts to refer an equal proportion of the total disputed claims to each independent reviewer. A provider may request, and the commissioner may allow, the claims of a provider involving the same health maintenance organization to be aggregated and submitted for simultaneous review by an independent reviewer when the specific reason for non-payment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The mere fact that a claim is not paid does not create a common substantive question of fact or law. The reviewer shall, within fourteen (14) calendar days of receipt of the disputed claim or claims, request in writing that both the provider and the health maintenance organization provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer shall request the provider and health maintenance organization to identify all information and documentation that has been submitted by the provider to the health maintenance organization regarding the disputed claim or claims, and advise that the reviewer will not consider any information or documentation not received within thirty (30) calendar days

of receipt of the reviewer's request unless the health maintenance organization or provider requests the independent reviewer for additional time to complete the investigation of independent review requests when a provider elected to aggregate their claims. Thereupon, the reviewer may grant the health maintenance organization or provider an additional thirty (30) calendar days. The reviewer shall then examine all materials submitted and render a decision on the dispute within sixty (60) calendar days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit, or the reviewer requests and receives an extension of time from the commissioner to resolve the dispute. In reaching a decision, the reviewer shall not consider any information or documentation from the provider that the provider did not submit to the health maintenance organization during that organization's review of the provider's disputed claim or claims.

(B) Should the reviewer need assistance on a medical issue connected with the disputed claim or claims, then the reviewer shall refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the TennCare Bureau, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may

respond to the request, refer the request to an independent contractor, or refer the request to the TennCare Bureau for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one (1) or more states in the United States. The appeals unit shall provide a concise response to the request within ninety (90) calendar days after receipt. If the appeals unit seeks the guidance of the TennCare Bureau on whether a benefit is a covered service, then the Bureau must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer shall make a final decision within thirty (30) calendar days of receipt of the appeals unit's response.

(C) The reviewer shall send the health maintenance organization, the provider, and the TennCare Division of the Department of Commerce and Insurance a copy of the decision. Once the reviewer makes a decision requiring a health maintenance organization to pay any claims or portion thereof, then the health maintenance organization must send the payment in full to the provider within twenty (20) calendar days of receipt of the reviewer's decision.

(D) Within sixty (60) calendar days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not

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brought within sixty (60) calendar days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be de novo without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching a decision, shall be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney's fees and expenses from the non-prevailing party. "Reasonable attorney's fees" means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or five hundred dollars ($500), whichever amount is greater.

(E) In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim. For all claims filed on or after October 1, 1999, the State may not mandate that the provider and health maintenance organization resolve the claims payment dispute through arbitration.

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(F) Providers who are owned by state or local governmental entities shall retain the statutory right of setoff if available. Judicial review of a reviewer's decision regarding a state or local governmental provider shall be in the chancery court of Davidson County, and not in the Tennessee Claims Commission, unless the provider and health maintenance organization have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney's fees and expenses awarded under subdivision (b)(3)(D).

(G) All costs associated with implementing these procedures shall be paid by the applicable health maintenance organization. However, the provider shall reimburse the health maintenance organization the independent reviewer's fee within twenty (20) calendar days of receipt of the reviewer's decision, if the reviewer finds that the health maintenance organization properly denied the claim being reviewed. If a provider fails to properly reimburse the health maintenance organization, the TennCare Division of the Department of Commerce and Insurance may prohibit that provider from future participation in the independent review process.

(H) The health maintenance organization shall compensate the independent reviewer pursuant to their written agreement within thirty (30)

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calendar days of the health maintenance organization's' receipt of the independent reviewer's bill for services rendered. If the health maintenance organization fails to pay any such bill for the independent reviewer's services, then the independent reviewer may request payment directly from the state from any funds held by the state that are payable to the health maintenance organization.

(I) The above procedures shall not apply to any claims filed with the health maintenance organization before October 1, 1999, even if that claim is refiled after that date.

(4) The commissioner shall appoint a panel of five (5) persons, known as the claims processing panel. The panel shall consist of two (2) provider representatives, one (1) representative from each of the two (2) health maintenance organizations with the largest number of TennCare enrollees, and the commissioner or the commissioner's duly designated representative. The panel shall select a chairperson, and all decisions of the panel shall be made by a majority vote of the members of the panel. The panel shall select and identify an appropriate number of independent reviewers to be retained by each health maintenance organization under subdivision (b)(3). The panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each health maintenance organization engaged in a TennCare line of business, as a condition of participating in this contract or in the TennCare program, shall contract with each reviewer and agree to pay the rate

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of compensation negotiated by the panel. The members of the panel shall not be paid. The panel shall meet at least twice a year.

(5) By no later than May 1 of each year, the commissioner shall report to the Department of Health and to the Fiscal Review Committee the number of requests for TennCare claims review filed for each health maintenance organization operating a TennCare line of business during the prior calendar year. The commissioner shall also generally report the outcome of these independent review requests for each health maintenance organization. In addition, the commissioner shall report the name of any provider whose claim denial is upheld in more than fifty percent (50%) of the independent review requests, as well as the number of claim reviews with the claims denial upheld.

(6) All claims for services furnished to a TennCare enrollee filed with a health maintenance organization must be processed by either the health maintenance organization or by a single subcontractor retained by the organization for the purpose of processing claims. However, another single entity can process claims related to each of the following: pharmacy, vision, dental or mental health benefits.

(7) The health maintenance organization shall ensure all its subcontractors processing TennCare claims follow the same claims processing and resolution procedures required by the Prompt Pay Act. TennCare claims processed by a subcontractor are subject to the prompt payment requirements of this statute. Claims denied by a subcontractor are subject to independent review.

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If a provider requests independent review of a claim denied by a subcontractor, the health maintenance organization contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the health maintenance organization the reviewer's fee. If the independent reviewer finds for the provider, the health maintenance organization contracted with the subcontractor must pay the provider within twenty (20) calendar days of the reviewer's decision.

(8) A health maintenance organization that subcontracts with another entity to obtain services for TennCare enrollees shall guarantee and assure the payment of all contracted amounts agreed to be paid to such providers by that entity or that entity's agent. This does not preclude the health maintenance organization from seeking reimbursement from the subcontractor for any amounts paid. Nor does this prevent the health maintenance organization from asserting any legal defenses to the payment of a provider's claims that were available to the subcontractor. Claims filed with a subcontractor are subject to the prompt payment requirements of this statute. Claims denied by a subcontractor are subject to independent review. If a provider requests independent review of a claim denied by a subcontractor, the health maintenance organization contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the health maintenance organization the reviewer's fee. If the independent reviewer finds for the provider, the health maintenance

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organization contracted with the subcontractor must pay the provider within twenty (20) calendar days of the reviewer's decision.

(9) Any health maintenance organization found by the commissioner to be in violation of Tenn. Code Ann. § 56-32-226(b) shall be subject to revocation or suspension of its certificate of authority under § 56-32-216 or, in the alternative, the imposition of the penalties and other remedies set forth at § 56-32-220.

SECTION 2. The purpose of this Act is to clarify the administration of independent review. Nothing contained herein shall be construed to alter a provider's right to pursue an action for breach of contract.

SECTION 3. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 4. This act shall become effective July 1, 2002, the public welfare requiring it. This act shall not affect any requests for independent review pending prior to the effective date of this act, and such requests shall be governed by the law in effect when such requests were filed with the commissioner.